



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Public Health Service

OMB No. 0937-0025  
Expiration: 7/31/2000  
PHS-50  
Rev. 7/97

**APPLICATION FOR APPOINTMENT AS A COMMISSIONED OFFICER IN  
THE U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS**

**BEFORE COMPLETING THE APPLICATION, READ ATTACHED INSTRUCTIONS CAREFULLY. GIVE COMPLETE ANSWERS TO ALL ITEMS.**

**TYPE OR PRINT IN INK.** If additional space is needed, attach an 8 1/2 x 11 inch sheet of paper. Include your name, address, social security number, and the pertinent item numbers on each sheet so used. All material submitted becomes the property of the Federal Government and will not be returned. Part of the information will be used for a suitability/background investigation. **YOU MUST SIGN THIS APPLICATION ON PAGE 4 OR YOUR APPLICATION WILL NOT BE PROCESSED.**

Submit signed original and a clearly readable copy (photocopy acceptable) with **original signature** to: Division of Commissioned Personnel, PSC, HRS, 5600 Fishers Lane, Room 4-20, Rockville, MD 20857-0001.

<b>1a. FULL NAME (Last, First, Middle)</b> _____ (Maiden, if Any)		<b>1b. OTHER NAMES USED</b> From: (MM/YYYY) _____ Through: (MM/YYYY) _____ (Continue in Item # 27 if needed)	
<b>2. SOCIAL SECURITY NUMBER</b> _____	<b>3. DATE OF BIRTH (MM/DD/YY)</b> ____/____/____	_____/____/____	_____/____/____

**4. TYPE OF DUTY(IES) FOR WHICH YOU ARE APPLYING:** (Indicate all that are applicable and appropriate, Dates MM/YYYY)

General Duty (extended Active Duty) Available for Active Duty: \_\_\_\_/\_\_\_\_/\_\_\_\_
  Junior COSTEP From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_
  Senior COSTEP From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**5. CURRENT INFORMATION FOR CONTACTING YOU: (YOU MUST NOTIFY DCP IMMEDIATELY OF ANY CHANGES)**

Mail: Street: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_ ZIP: \_\_\_\_\_ + \_\_\_\_\_

Telephone (Include Area Code):  
 Current: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Business: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_  
 FAX: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 E-Mail: \_\_\_\_\_

**6. "PERMANENT" INFORMATION FOR CONTACTING YOU:**

Mail: Contact Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_ ZIP: \_\_\_\_\_ + \_\_\_\_\_

Telephone (Include Area Code):  
 Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Business: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_  
 FAX: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Any additional information should be listed in Item # 27.

**7. CITIZENSHIP INFORMATION**

Native  Naturalized Place of Birth: \_\_\_\_\_  
 If Naturalized: Date Naturalized: (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Name on Certificate: \_\_\_\_\_

**8. BASIC EDUCATION AND PROFESSIONAL TRAINING** (Include below, all degrees you have earned or training you will have completed by the time you are available for appointment. Official transcripts to include final or latest grading period for all college, graduate, and professional training MUST BE SUBMITTED BEFORE SELECTION CAN BE MADE.)

COLLEGE, UNIVERSITY, OR OTHER INSTITUTION (Include City, State, and ZIP)	DATES ATTENDED FROM (MM/DD/YYYY) TO (MM/DD/YYYY)	TOTAL HOURS CREDIT (Specify Qtr. or Sem.)	MAJOR	DEGREE	OFFICIAL NUMBER YEARS IN PROGRAM	DEGREE REQUIREMENTS FULFILLED (MM/YYYY)	DEGREE CONFERRED OR TO BE CONFERRED

**INTERNSHIP OR RESIDENCY COMPLETED (MUST PROVIDE CERTIFICATE), CURRENTLY SERVING, OR SCHEDULED TO COMMENCE**

HOSPITAL OR INSTITUTION (Include City, State, and ZIP)	FROM MM/YYYY	TO MM/YYYY	SPECIFY TYPE AND SPECIALTY (if applicable) (e.g. Rotating, Mixed, or Straight, Categorical, Surgery, Family Practice)

**9. UNIFORMED SERVICE:** List below in chronological order all service you have had in the ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, and the COMMISSIONED CORPS OF THE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION or the PUBLIC HEALTH SERVICE. Include any present military affiliations: PHS, Reserve Unit, ROTC commitment, etc. Except for PHS affiliation, you must initiate a release from such Service contingent upon your appointment to the Commissioned Corps of the PHS or provide proof of discharge.

SERVICE COMPONENT	REGULAR OR RESERVE	HIGHEST RANK HELD	DUTY FROM (MM/DD/YYYY) TO (MM/DD/YYYY)	ACTIVE OR INACTIVE DUTY

**10. Were you ever rejected for duty in any branch of a Uniformed Service?**  
 Yes  No (If "Yes", state when and where rejected and cause)

**11. DEPENDENTS INFORMATION** (Full name of spouse and full name(s) and date(s) of birth of child(ren) and/or other dependent(s))

(Name)	(Relationship)	(Date of Birth: MM/DD/YYYY)
	<b>SPOUSE</b>	____/____/____
		____/____/____
		____/____/____

Indicate Answers by Placing an "X" in the Appropriate Column.

YES NO

- 12. Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or for any firearms or explosives violations? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.
- 13. During the past seven years, have you been convicted, imprisoned, on probation or parole or forfeited collateral, or are you now under charges for any offense against the law not included in item 12 above? (When answering items 12 and 13, you may omit: (a) traffic fines for which you paid a fine of \$150.00 or less, (b) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (c) any conviction the record of which has been expunged under Federal or State law, and (d) any conviction set aside under the Federal Youth Corrections Act or similar State authority.)
- 14. Are you delinquent on the repayment of any Federal debt(s)? If your answer is "Yes," please provide an explanation in item 27. (Examples of Federal debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of direct and guaranteed loans are any loan(s) more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent.)
- 15. Are you a conscientious objector to military service? (If "No" go to question 17)
- 16. If you are a conscientious objector, are you willing to serve in a noncombatant position? (NOTE: By Executive Order, the PHS Commissioned Corps may be militarized during times of national emergency and does have officers serving in support roles at all times. If in item 15 you stated an objection, you would be precluded from appointment in the Commissioned Corps of the Public Health Service.)
- 17. If in the military service, were you ever convicted by a general court martial?
- 18. Have you ever been charged with, or are currently facing charges, of a violation of any State law pertaining to habit-forming drugs, narcotics, or intoxicating liquor? (NOTE: If your answer to items 12, 13, 14, 17, or 18 is "Yes," give details in item 27. Show for each offense: (a) date, (b) charge, (c) place, (d) court, and (e) action taken.)

19. **REFERENCES** List the names of four individuals, including your most recent employer, with whom you have had professional affiliation or training at some time during the past seven years. Include, where applicable, Dean of College; Dean of Graduate or Professional school; Director of Intern Training Program; Director of Graduate, Post-Graduate, Residency, or Specialty training; chairpersons of departments in which graduate or professional work was taken; or employment supervisors.

FULL NAME	PROFESSIONAL RELATIONSHIP TO APPLICANT	BUSINESS ADDRESS <i>(Organization and Street, City, State, ZIP, Telephone)</i>
1) _____	_____	_____ _____ _____ (____) _____ - _____
2) _____	_____	_____ _____ _____ (____) _____ - _____
3) _____	_____	_____ _____ _____ (____) _____ - _____
4) _____	_____	_____ _____ _____ (____) _____ - _____

20. **LIST STATES GRANTING FULL/UNRESTRICTED PROFESSIONAL LICENSES/CERTIFICATES** (Include license or registry number and expiration date and provide a copy of the license/registration)

\_\_\_\_\_

\_\_\_\_\_

21. **DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE REGISTRATION INFORMATION**

(If you were never registered, so state)

A. List all jurisdictions (past and present) where you are or were registered under Title 21, U.S. Controlled Substances Act, and provide your DEA controlled substance registration number for each jurisdiction.

\_\_\_\_\_

\_\_\_\_\_

B. Has your registration under this Act ever been denied, suspended, revoked, refused renewal, or voluntarily surrendered?	YES	NO
C. Have you ever been charged with, or are currently facing charges of, a violation of this Act?		

23. **EXPLAIN ALL "YES" ANSWERS IN ITEM 27.**

	YES	NO
A. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical or professional organization?		
B. Have you ever lost or had your professional practice license revoked?		
C. Have liability claims been filed against you, or against a hospital, corporation, or government based on a case under your care?		
D. Have judgements or settlements been made against you, or against a hospital, corporation, or government based on a case directly under your care?		
E. Have you ever had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused renewal?		
F. Have you ever been censured or reprimanded by a licensing board, hospital medical board/staff, or any other professional organization?		
G. Have you ever been sanctioned by the Medicare or Medicaid Programs or by any other Federal agency?		
H. Have any or all of your privileges at any health care facility ever been, or are about to be, limited, suspended, revoked, refused renewal, or voluntarily surrendered?		

22. **STATUS IN PROFESSIONAL BOARDS** (Indicate date and type of board, and whether Board Eligible, Board Certified, or Board Examination has been taken. Submit copy of ECFMG Certificate and Board Certification, if any.)

\_\_\_\_\_

\_\_\_\_\_

24. **Provide the names and addresses (past and present) of all of your professional liability insurers and your policy numbers.**

\_\_\_\_\_

\_\_\_\_\_



**25. EMPLOYMENT HISTORY**

Begin with current or most recent work or volunteer experience and work back. Account for any periods of unemployment exceeding three months on the last line of the experience blocks in order of occurrence. Do not list any employment prior to commencing undergraduate school. For your PROFESSIONAL EXPERIENCE AND WORK RECORD, include professional training positions not reflected in item 27. Include assistantships, apprenticeships, and fellowships. Describe your duties, including: (a) professional skills involved; (b) degree of responsibility; (c) complexity of duties; (d) extent of supervision received and exercised; (e) extent of public contact; and (f) extent of influence on policy.

DATES EMPLOYED (MM/YYYY) From: ___/___/___ To: ___/___/___		EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION		YOUR POSITION TITLE / MILITARY RANK	
EMPLOYER 'S / VERIFIER'S STREET ADDRESS		CITY (Country)	STATE	ZIP (+4) _____ + _____	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION		CITY (Country)	STATE	ZIP (+4) _____ + _____	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS (If different than Job Location)		CITY (Country)	STATE	ZIP (+4) _____ + _____	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK (If less than 40 hours state specific schedule)		KIND OF BUSINESS OR ORGANIZATION (e.g., education, health, social services, etc.)			
REASON FOR LEAVING OR WISHING TO LEAVE					

DESCRIPTION OF WORK (Describe your specific duties, responsibilities, and accomplishments in this job.)

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